



Synsvoll Chiropractic Clinic

“Experience the Gonstead Difference”

Social Security No. _____

Date _____

CONFIDENTIAL PATIENT INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital Status **M S W D** How Many Children? _____

Email address _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone _____

Patient's Nearest Relative _____ Phone # _____

Referred By _____

Primary Care Physician _____ **Phone #** _____

Address _____ **Date of last exam** _____

Have you ever suffered from: (circle one)

Dizziness Yes No	Back aches Yes No	Heart Trouble Yes No	Diabetes Yes No
Tuberculosis Yes No	Arthritis Yes No	Headaches Yes No	Asthma Yes No
Neuritis Yes No	Anemia Yes No	Nervousness Yes No	Sinus Trouble Yes No
Cancer Yes No	Digestive Disorders Yes No		

Purpose of this Appointment _____

Other Doctors seen for this condition _____

Has a physician treated you for any health condition in the last year? **Yes No**

Describe _____

Remarks and additional information _____

Is this related to a motor vehicle accident or workman's comp? **Yes No** Please specify _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Are you insured? **Yes No** Name of Insurance Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the staff of Synsvoll Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Synsvoll Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Name _____

Date _____

Rate the pain you have right now:

[-----]
Absent Severe

Rate your pain at its best in the past week:

[-----]
Absent Severe

Rate your pain at its worst in the past week:

[-----]
Absent Severe

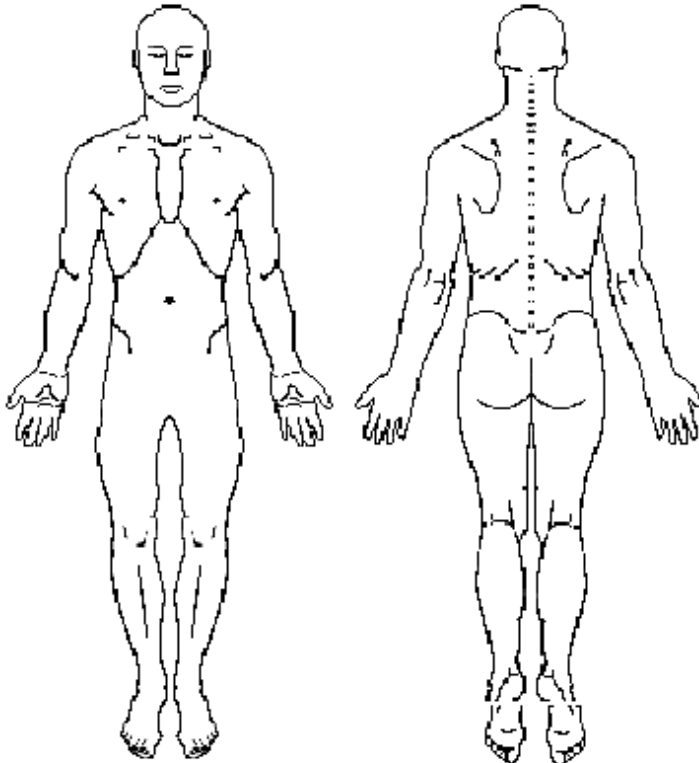
Rate your average pain in the past week:

[-----]
Absent Severe

A=Ache
P=Pins & Needles
M=Misalignment

B=Burning
S=Stabbing
E=Edema

N=Numbness
O=Other





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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them and understand them or declined the opportunity to read them. I understand that this form will be placed in the Privacy Act binder and maintained for seven years.

Patient Name (Please Print)

Date

Parent, Guardian or Patient's Legal Representative (Please Print)

Signature

I hereby give consent for my spouse or family member to obtain medical and financial information.

Person(s) allowed information _____

Signature

Date

This form will be placed in the Privacy Act Binder and maintained for seven years.

101 NW 12th Street, Suite 125 Battle Ground, WA 98604
(360) 687-6308 FAX (360) 687-6309



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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above mentioned statements.
(print name)

All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(parent signature)

(date)

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

(signature)

(date)